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THE HAMPDEN HIPPOCRAT

JULY-AUGUST 1990
VOLUME XXXXV NO. 9

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On our cover is Hillcrest Hospital in Pittsfield, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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(Chicago) Trying to decide if it still makes sense with the new tax law for your practice to be incorporated? the all-new edition of *A Physician's Guide to Professional Corporations* can help you resolve this question.

Available from the American Medical Association, the book explains the pros and cons of incorporation, and clearly outlines legal and tax implications. It clarifies the rules of operating a professional corporation by translating this complex issue into common terms using a point-by-point approach.

This authoritative publication addresses the following topics:

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A Physician's Guide to Professional Corporations, OP 378289, is available at $18.00 for AMA members ($27.00 for nonmembers), from the American Medical Association, Book and Pamphlet Fulfillment, P.O. Box 10946, Chicago, IL., 60610-0946, or call 1-800-621-8335 with VISA or Mastercard to order. ■

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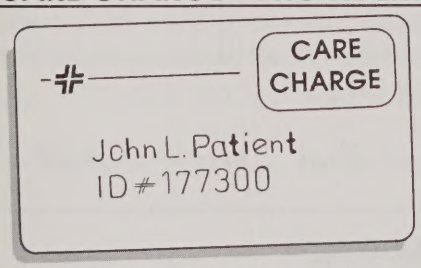

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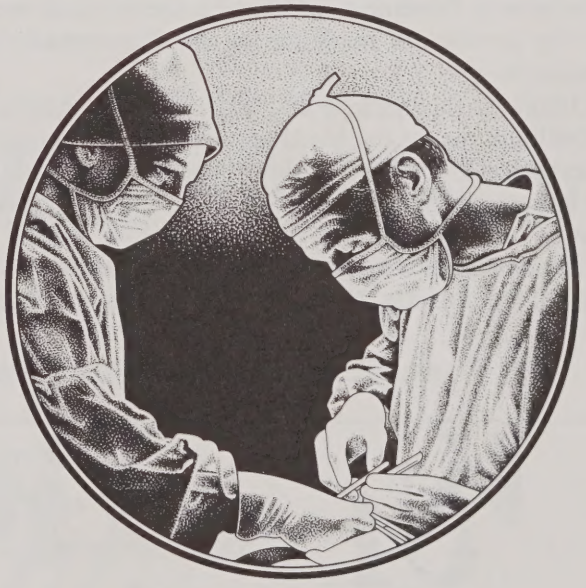
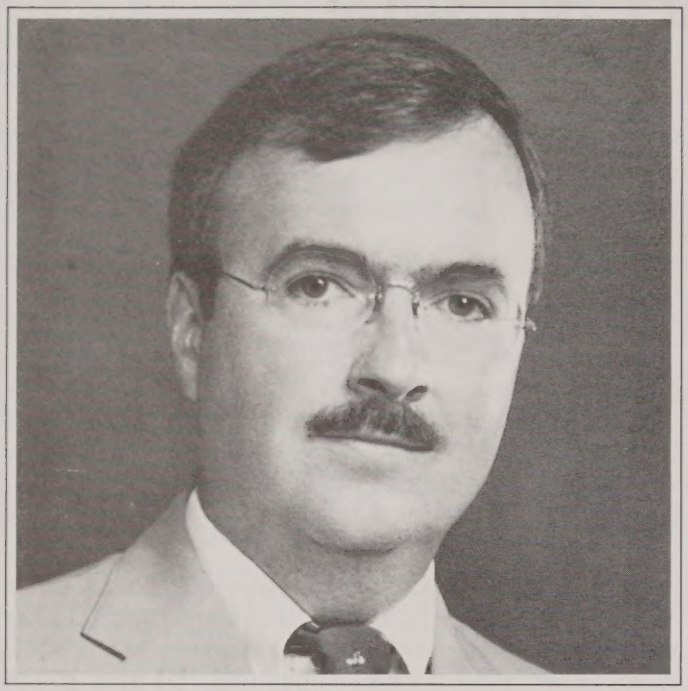


The Good Old Days
Hampden Hippocrat, May-June, 1990

Several individuals have written expressing concern over what they perceived as an "ethnic slur" in my essay. I sincerely apologize for any offense my article may have given.

Donald J. Higby, M.D.

HDMS President's Message



Joseph P. Keenan, M.D., President

The coming year should prove to be an exciting one. The political parties have chosen their nominees and the campaign will really start to heat up. The person elected Governor in November will have a tremendous impact on the practice of medicine in the Commonwealth of Massachusetts.

Organized medicine should take its rightful role in contributing its voice to selection of the next governor and attempting to influence political decisions that will have an impact on the practice of medicine over the next four years.

The Hampden District Medical Society, in concert with the Massachusetts Medical Society, has instituted a Political Candidate Series to facilitate this necessary dialogue between the medical community and our elected leaders. The forum at Baystate Medical Center in May featured William Weld, the Republican candidate, and his comments revolved around the need for less regulation in medicine and the need to bring meaningful tort reform to our current malpractice system. His comments were well received. I would invite all of you to attend the next meeting which will be held at Mercy Hospital in June and will feature Steve Pierce, the nominee of the Republican Party.

This is an exciting year. It will be a pivotal year. It is the year to become involved in the political process. We all heard at our annual meeting of the general low esteem in which the medical profession is held by politicians. The basic reason is that we don't vote and don't contribute—as a result, our opinions don't count. We, as individuals, have the opportunity to change that this year. It was especially disturbing to hear that only about 50% of physicians have even bothered to register to vote. Hopefully, that will change.

The so-called "Springfield 24", currently down to about half that number, are hopefully nearing the end of their long battle with the Attorney General. The outcome of this case will be closely watched from around the country. If justice is to be found in the judicial system, the charges against the defendants will be dropped. This whole process was a thinly-veiled attempt to coerce the physicians to participate in an insurance plan, namely Blue Cross/Blue Shield, that was not in their interests to do so. The case has more to do with the political power enjoyed by Blue Cross/Blue Shield rather than any anti-competitive trade practice on the part of the physicians, as charged by the Attorney General, James Shannon. We all anxiously await the judgement of the trial judge.

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A question that I frequently hear from my physician colleagues, is what is the Hampden District Medical Society doing for me. Physicians don't bother to join, or if they are members, don't bother to attend meetings. I think there are two aspects to this problem: (1) apathy on the part of the doctors and (2) the Hampden District Medical Society not filling a need. When an organization, such as the Hampden District Medical Society, with a membership of 600, can only muster about 10% of the membership for the district meeting three times a year, then something is wrong. The needs of the average physician member are not being met.

Over the next year, my major goal will be to discover the needs of members and attempt to have the Society meet those needs. I ask for your help, comments and ideas. As individuals, we can accomplish little; as an organization, we can accomplish much more. ■

New Regulation

Children must present evidence of having been previously screened for Lead Poisoning as a condition for entry to Kindergarten. ■

Editor's Workshop

A medical journalism workshop will be conducted by Sandoz Pharmaceuticals *in the Boston area on Saturday, November 10, and Sunday, November 11, 1990.* The meeting will be unique in many ways, notably:

1. the only Sandoz workshop this year (the last one was in September 1989 in Chicago),
2. the first Sandoz workshop to be a full two days,
3. the first Sandoz workshop to be in New England.

The meeting will be at the Hyatt Regency in Cambridge. Located on the Charles River, this first-class hotel is within walking distance of Harvard, M.I.T., and Boston University and a few minutes drive from Faneuil Hall, Symphony Hall, many museums and the historic sights of Boston.

Sandoz will provide, at no charge, the workshops, Saturday and Sunday lunches, Saturday reception and Sunday breakfast for any number of people from each publication. In addition, Sandoz will provide each publication with one hotel room for one night.

To make a hotel and/or workshop reservation, write to Richard Weiner, Porter/Novelli, 1633 Broadway, New York 10019. ■

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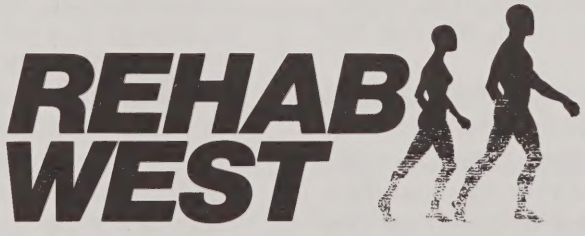

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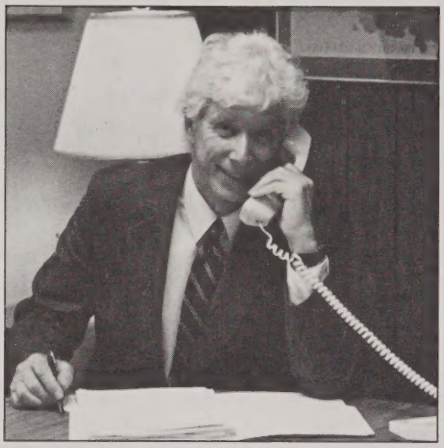
Hillcrest Hospital

This is the ninth in a continuing series of articles featuring Western Massachusetts Hospitals

PITTSFIELD—Hillcrest Hospital, a voluntary, acute care 130-bed community hospital situated in a beautiful lakeside setting, provides the highest quality of professional skills and medical technology for patient care to residents of Berkshire County and nearby New York State.

Through its staff of 170 physicians, modern facilities and state-of-the-art equipment the Hospital is a major element of Hillcrest Foundation, which is finding new and innovative ways to meet the needs of a changing society. The Foundation also includes the Hillcrest Educational Centers, a leader in providing special needs education to 150 students; Salisbury Estates, which offers gracious affordable retirement living; and BEST, an employee assistance program offered to local governments and businesses.



Eugene A. Dellea,
Administrator of Hillcrest Hospital

Since its founding in 1908, the hallmark of Hillcrest Hospital has been its friendly, caring, family atmosphere, an ambience that continues to highlight the Hospital's approach to patient care.

Hillcrest Hospital was established in 1908 by Dr. Charles Harper Richardson, a surgeon who saw the need for a surgical hospital in Pittsfield. The first home of the voluntary, nonprofit hospital was in a rented house on North Street, the former Maplewood School dormitory.

In 1909, Hillcrest signed a contract with General Electric Co. to provide pre-employment physical examinations and to care for GE employees involved in major industrial accidents. A nursing school was established the same year.

By 1911, the hospital had extended its services to medical as well as surgical patients. A maternity department was opened in 1926 and in 1938, Hillcrest had grown to 42 beds.

One of the most significant events in the hospital's history came in 1948 when Hillcrest purchased for $145,000 the Salisbury Estate in West Pittsfield on the shores of Onota Lake and converted the 67-room mansion to a 100-bed hospital. Hillcrest occupied the new facility in 1951. Twenty years after its move to Tor Court, Hillcrest completed a $3.3 million addition, providing for expansion to 130 beds.

The Hillcrest Family Health Center with a strong emphasis on family medicine and 1-stop health care, opened in the mansion in 1977. The Center's steady growth necessitated the construction of a $1.6 million addition, which was dedicated in 1988 in honor of Judge John A. Barry, president and Chairman of the board of Hillcrest Hospital and the Hillcrest Foundation.

While the Hillcrest Family is proud of its past, it looks to the future to build on its accomplishments and make an even greater contribution to the quality of life in the Berkshires.

The tone for that future is set by Judge Barry, the Hospital's volunteer board of directors and Eugene A. Dellea, the hospital's longtime administrator. "We look to the future with an extremely positive attitude and with plans that are as dramatic as any project we have undertaken in the past," Judge Barry said in the Hospital's 1989 Annual Report issued recently.

He cited the planned construction of Salisbury Manor, a $6.8 million facility for long-term skilled care in a 123-bed unit of West Street, which will complement Salisbury Estates and Hospital. The project, Salisbury Manor, will meet a pressing community need for high quality health care on a long term basis.

If there are no delays, construction should begin by 1991. The facility is expected to be operational by mid-1992. It will be built on a seven-acre site and contain three special units: an Alzheimer's unit, sub-acute care unit, and a general level I-II nursing unit, which is similar to modern conventional nursing homes.

The one-story facility will include respite beds for the elderly, adult day care for use by the community and child day care for use by the staffs of the Hospital and Salisbury Manor.

Salisbury manor will build on the excellent existing hospital facilities, which provide state-of-the-art medical technology in a full range of patient care services. Just in the past year, the Hospital has added a General Electric CT scanner giving Hillcrest the capability of offering round-the-clock diagnostic imaging service; patient care bedside monitors that represent the latest space age technology in the Critical Care and Intensive Care Units; new x-ray equipment; and a computerized clinical chemistry system, a sophisticated laboratory instrument that automatically analyzes blood serum and other body fluids rapidly and accurately.

Among the hospital's special units is the Family Health Center, situated in a special wing dedicated to the practice of family medicine, including pediatrics and a program addressing women's health concerns. The Center is the base for the Hillcrest Community Health Plan, the

first health maintenance organization in the Berkshires, which has grown to more than 10,000 members with satellite Health Centers in Great Barrington and Lee.

The Hospital's Thomas W. McGee Unit for Alcohol and Substance Abuse Treatment, named for the former Massachusetts House Speaker so instrumental in its establishment, is meeting another critical need in the community.

A new mammography suite offers comfortable, living-room atmosphere to put patients at ease. Refurbishing of the hospital's third floor was completed recently. New paint and wallpaper, curtains and carpeting provide patients with bright and cheerful surroundings.

Hillcrest's Emergency Department treats more than 16,000 patients annually. The hospital's modern surgical suite accommodates both in-patient and out-patient procedures. The Radiology Department, with its CT scanner and new x-ray equipment, offers the finest in diagnostic imaging technology.

Hillcrest has maintained its high quality of patient care in the face of increased regulation and intense pressure to contain costs. The Hospital's recent three-year full accreditation by the Joint Commission on Accreditation of Healthcare Organizations, attests to the excellence of patient care.

Hillcrest is meeting the challenge. A restructuring of the staff and intensive cost containment efforts have enabled the hospital to position itself as it moves into the nineties.

Dellea says that in order to fulfill its mission, "a hospital must keep pace with the times, providing the best possible medical technology, making necessary and prudent improvements to the facility, and adding appropriate services for which there is a demonstrated need."

From its beginning as a 10-bed surgical facility on North Street to its modern 130-bed Hospital at the former Salisbury estate on the shores of Onota Lake, Hillcrest Hospital has fulfilled the need for quality medical health care in the Berkshire community, a goal it is committed to continue into the 21st Century. ■

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Regional Column

The image of those in the profession of medicine is often formed by individuals outside the discipline. These decision makers, whether political, social or scientific should have the opportunity to witness the delivery of care, firsthand, as you, the medical professional, do in daily practice.

To this end, Nancy L. Weiss, M.D., immediate past president, Hampden District Medical Society, spearheaded the first Doctor-for-a-Day, Mini-Intern Program. This community education initiative, held on April 27, 1990, brought legislators and selected physicians together to spend a day in the practice of medicine.

Legislative interns were matched with constituent physicians in the medical specialty of their choice. Following the internship, it was our hope that both participants would feel comfortable consulting with each other regarding health policy and legislative issues. In fact, several physicians are scheduled to spend a day with their legislative intern on Beacon Hill.

The program had three parts. At 7:00 a.m. on Friday, April 27, legislative interns and their physician faculty gathered for an orientation breakfast. This was an opportunity for participants to meet and to discuss views about health issues and the medical profession.

Each legislative intern then spent the day with their faculty physician during office hours, surgery, hospital rounds and nursing home visits. It is important to mention that nothing was "staged" for the legislative intern. The goal was to impart to the intern a realistic illustration of patient care in Massachusetts.

One might wonder about patient reaction and acceptance of the legislative intern. In all but a few cases, patient response was excellent. Most patients not only allowed the intern to observe, but they also engaged the intern, who in many cases was their own legislator, in discussion.

On the eve of the program, the legislative interns and program planners gathered for a debriefing dinner. This evaluation session allowed for the opportunity to critique the day's events, and to compare preconceptions with actual experience.

All legislative interns claimed that they had never been offered an experience like the Doctor-for-a-Day program. One stated that "this is the only constituency group that I've ever done anything at this level with." "I've met with doctors before, and heard their problems, but to see what they have to do on a daily basis ... I was very impressed."

Another intern summed up his experience by saying that "today allowed us to be put in their shoes and to see what doctors have to do on a day-to-day basis." "We were able to get past much of the anger and frustration that we usually hear, and see first-hand what occurs."

Many health issues were raised by the legislative interns. One intern was astounded by the magnitude of free care provided by his physician faculty. Another mentioned that "in the back of their (the physicians') minds the issue of medical malpractice is always there, and really impacts on how they treat their patients."

Physicians also gain from their participation in the program. The faculty was unanimous in stating that the day with their legislative intern was "time well spent." A participating physician now has the opportunity to be more politically active, as the Doctor-for-a-Day program has helped them forge a unique relationship with their local legislator.

The Hampden District's Doctor-for-a-Day program was a pilot project, one it is hoped will be conducted on an annual basis as well as emulated across the state. If you would like more information, or to be included in the future programs, please contact the MMS West Central Regional Office at 1-800-552-3112. ■

Kerin L. Milesky
Regional Coordinator

Standing left to right: Thomas Clarke, M.D., Senator Brian Lees, Representative Robert Howarth, Representative Iris Holland, Representative Paul Caron, Representative Michael Walsh, Representative Athan Catjakis, Peter Greene, M.D., and John Papale, M.D.

Seated left to right: Joan Fine, M.D., Evan Gold, M.D., Nancy L. Weiss, M.D., Anthony Kusiak, M.D., and Roger Beneitone, M.D.

A Lesson Re-Learned

During my four years at Tufts Medical School there were two outstanding rules concerning the practice of Medicine which were stressed, then deeply ingrained into my memory. The first, well-known and oft-repeated was 'PRIMUM NON NOCERE.'

The second, less famous but equally important, was 'Never change the way you practice based on an isolated article in the New England Journal of Medicine.' (At that time referred to as the 'Brown Journal' because of its paper wrapper). Since my graduation in 1974, I have tried my best not to violate the first rule, and NEVER the Journal Rule. Until recently.

In 1985, during a time of dramatic and traumatic changes in practice styles and ideas in the Springfield (Mass) area, a colleague showed me a Journal article entitled 'Antitrust enforcement in Health Care'. (1) I read the article, I re-read the article, then read the article a third time until I thought I understood what it meant, as if preparing for a new procedure.

I made sure that the indications for the procedure were clear, I weighed the risks and the benefits of the proposed procedure, and then I carried it out: I submitted a letter notifying Blue Shield of Massachusetts of my intention to resign as a particiating physician. The required twelve months notice had been given in order to keep things legal. Or so I thought.

I carefully adhered to the principles and cautions outlined in the article mentioned, in order to avoid any complications: No agreements were made, no demands for higher fees were made, and there was no attempt to be anticompetitive (whatever that is). Most importantly, the procedure (resignation) was carried out as an individual and not through any medical society. Unfortunately for me, other physicians in the area had already, and did subsequently carry out similar procedures.

Alas, I have re-learned not to depend on an isolated Journal Article to guide me through what was for me a new procedure. Three years later I am a defendant in an antitrust suit against the so-called "Springfield 24" (officially known as COMMONWEALTH OF MASSACHUSETTS vs. CHARLES W. CAHILL, et al).

It would appear that physicians still have a meager (at best) understanding of how to properly perform similar procedures and other operations involving antitrust issues. I do not believe that antitrust conduct is even mentioned in medical school or residency, with the possible exception of the OB-GYN residency at Baystate Medical Center in Springfield. Residents here are getting a "hands-off" experience in antitrust procedures.

Perhaps it is time that antitrust law be included in residency training in order prevent similar unfortunate outcomes. Practicing physicians might also benefit from such training, as evidenced by Mr. Rule's speech at the recent AMA convention (2). ■

Charles Wm. Cahill, M.D.
Springfield, Massachusetts
January 10, 1989

(1) Costile, LB, Antitrust enforcement in health care: ten years after the AMA Suit. N Engl J Med 1985; 313:901-4.
(2)Rule, CF, Antitrust enforcement and the Medical profession: no special treatment. Remarks at the Interim Meeting of the AMA House of Delegates, Dallas, TX 6 December 1988.

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Physicians For Social Responsibility

Ira Helfand is an emergency room physician at Cooley-Dickinson Hospital in Northampton. He is a national treasurer of Physicians for Social Responsibility and active in the local chapter as well. Physicians for Social Responsibility is a national organization dedicated to publicizing the health consequences of nuclear war.

Hampden Hippocrat: Tell us about PSR.
Helfand: Nationally it has about 30,000 members. Locally there are about 180 members in Western Massachusetts. It's the 10th or 11th largest medical group in the country. The Board of Sponsors include people like Thomas Chalmers, Alexander Leaf, Bernard Lown, Sid Alexander and Herb Abrams.

HH: When was it started?
Helfand: It was actually founded in 1961 by Bernard Lown around the Nuclear Test Ban Treaty and those issues. It became inactive in the early 1970s. Then in 1978 I was speaking on antinuclear issues and I called up Helen Caldecott who was also speaking on antinuclear issues—to get more information and books. While I was xeroxing these, she and I talked about starting an organization. She mentioned that another physician, Eric Chivian, was also interested. Then we ran into some of the old members of PSR who said there already was such an organization and PSR was reinvigorated in 1978. It just started growing. We decided to go for broke and bought a full page ad in the NEJM of March 30, 1979 about the medical consequences of nuclear power. By pure chance this was the day after Three Mile Island and the membership took off from there.

HH: Is there an active PSR chapter in Western Massachusetts?
Helfand: The two chapters, the Pioneer Valley Chapter in Northampton and the Springfield Chapter merged in 1989. The two major activities locally are opposing anthrax research (biological weapon defense research—HH) space at the University of Massachusetts and we have been successful in getting a review committee to investigate this. We are also trying to set up a hearing mechanism to review military research at UMass. Statewide, Representative Barbara Hildt of Amesbury has introduced legislation banning biological warfare research and PSR is supporting her.

HH: Is biological warfare becoming a national issue for PSR?
Helfand: It is something the national organization is examining. The Utah chapter has been active in opposing the national testing facility for biological warfare research at Dugway and a few other chapters are interested as well, although we and Utah are the only chapters which have been active (in opposing specific biological weapons research).

HH: What else are you doing locally?
Helfand: The main theme is work on the budget and the appropriation of funds for the military. April 16, Tax Day this year, we had a White Coat Presence at the Post Office in Northampton, to hand out leaflets explaining our position on cutting military spending. We are also trying to set up a meeting with Congressman Conte about this.

In May we are planning two town meetings, one in Holyoke and one in Northampton, to discuss the budget. We have invited the congressional representatives and Senators (John) Kerry and (Edward) Kennedy. Mayor Musante will preside in Northampton. This will be an opportunity for citizens to discuss the budget. There will be representatives from the schools, from labor and from the local business community as well as PSR there.

You know, a year ago they said we needed to have a $300 billion military budget because of the threat from the Warsaw Pact and now that there is essentially no Warsaw Pact they still want $300 billion. Several Congress members and a broad coalition of groups concerned with military spending including PSR have proposed a Budget for a Strong America which calls for a $280-$285 billion military expenditure and reallocation for health and education. Time and Fortune magazines are calling for deeper cuts to $260 billion.

HH: Some people think that money cut from the military should be used to reduce the budget?
Helfand: You can't reduce the budget at the expense of human services. In the last decade a trillion dollars extra was spend on the Reagan military build up at the same time health, education and maintenance of the infrastructure—roads, bridges—were underfunded. More and more kids aren't immunized, many kids can't read.

HH: Is it a proper role for a physician organization to be involved in these issues?
Helfand: It is not a new role for physicians. We have been involved in advocacy for public health from the beginning of organized medicine. And if we want a healthy Society we need housing, education.

HH: With the changes in Europe people are losing interest in peace issues. How is PSR approaching that?
Helfand: This moment in history is an extraordinary opportunity to undo the structural damage to this country caused by massive diversion of resources from domestic needs to military spending. The Reagan administration existed to divert money to the defense industry, from the entire country but particularly from the poor and middle class. Even if you don't agree that military spending in the last decade was unnecessarily high, now the majority of Americans believe that military spending should be cut. The Bush administration, almost

alone in this country—and defense contractors—doesn't want to do this. I think this shows a lack of vision and understanding that America's preeminence isn't derived from military strength, that this military spending is weakening our economic position.

The Cold War establishment—diplomats, soldiers, industrialists—are having an identity crisis. They don't know what to do or what their raison d'etre is anymore.

HH: There is a Soviet equivalent of PSR. Are they continuing to be active?
Helfand: Yes, the Soviet Committee of Physicians for the Prevention of Nuclear War. You know Gorbachev has been better on nuclear issues than the United States. He declared a unilateral moratorium on nuclear testing and the United States wouldn't go along. He even extended it for 18 months. He wants a treaty to stop all nuclear testing. But the physicians in the Soviet Union don't think this goes far enough. They support reinstitution of a full moratorium on testing. They support the efforts of the Kazazch Republic to close the nuclear testing site at Semipolitinsk, where there have been many demonstrations (against nuclear testing.) They are organizing an International Congress on Weapons Testing in Alma Ata in late May.

HH: What other issues do you see PSR exploring in the future?
Helfand: We have a working group on environmental issues and the health impact of such things as toxic pollutants and global warming. As part of an environmental campaign we are considering an aggressive campaign against smoking.

HH: Can you explain that a little more?
Helfand: Organized medicine has proposed voluntarism, Smoke Outs. I propose a health tax on cigarettes. Tobacco does $52 billion of damages to health in the United States each year. There could be a tax on each pack of cigarettes to pay for it. The ongoing sale of cigarettes to minors is a disgrace. The laws banning sale of tobacco to minors are not enforced. I would like to see a ban on all vending machine sales (of cigarettes). You know, at a time when we demand that other countries halt drug production and traffic, and are using our military to do this, we allow tobacco companies to actively promote cigarettes in the third world to shore up the market they are losing here. I think we should ban the export of tobacco products.

This is part of our practices every day. PSR will probably organize a task force on smoking. Any physician interested in being part of the task force should contact me.

HH: How can physicians who are interested join or become more active in PSR?
Helfand: We meet the last Tuesday of every month at 7:30 p.m. in Conference Room C at Cooley-Dickinson Hospital. Or people can call me at home 584-5933 or at work 582-2108. ■

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Resident Work Hours and Legislation

EDITOR'S NOTE: *Dr. Kathy O'Connor, a second year general surgery resident at Baystate, is the only area representative on the Massachusetts Resident Advisory Council. Here is her report of the Council's recent activities.*

Ever since the media extravaganza over the Libby Zion case in 1984 awed subsequent legislation regarding resident work hours in the state of New York, various other states have toyed with proposed or actual legislation along the same general lines. Before that case, the general public knew very little about residency training and work hours. Because of the growing public concern in this state and nationwide, the Coordinating Committee under the chairmanship of Dr. Egdahl was formed in 1987 by the MMS to study the issues involved and the current status of residency conditions in Massachusetts. This committee included representatives from the four major academic centers—Harvard, Tufts, BU, and UMass, as well as representatives from the Department of Public Health, Board of Registration and the Massachusetts Hospital Association. There were four residents—one each from Pediatrics, Obstetrics/Gynecology, Internal Medicine, and Surgery (Urology). There were no representatives at an administrative, staff or resident level from either of the programs in western Massachusetts, Baystate or Berkshire Medical Center (these two centers train 200 or more residents). The Committee worked over a nine month period and came out with the "First Report on Guidelines for House Staff Monitoring and Clinical Training Conditions" in October 1988.

At the request of then MMS president Dr. Joseph O'Connor, the Massachusetts Resident Advisory Panel (MRAP) was formed to review the report from the residents' perspective. It was an independent body designed to include representatives (voluntary) from all specialties. Their first meeting was in December, 1988. I joined them in January. 1989, as the only non-Boston based resident. The goal was to review the Committee's report from the residents' perspective and make recommendations about specific issues or propose issues that had not been originally considered.

The process was complicated when in January, 1989, a bill was brought to the Massachusetts House of Representatives. A proposal "to improve the quality of patient care... by limiting resident physician hours of work. "The Key section read as follows: No hospital shall schedule, require or allow a resident physician to work more than 72 hours per week, averaged over a 4-week period; and provided further... to have a work shift more than 16 consecutive hours, and that no resident physician shall have more than 12 consecutive hours of emergency room duty.

Each hospital shall conform to the following minimum requirements for working hours... (1) minimum of 8 non-working hours between any two work shifts, (2) one consecutive 24 hour non working period each week...

Hearings and possible action in the legislature were scheduled in March.

Between both January and March, MRAP met every other week to draft recommendations for the Committee as well as prepare to give testimony at the hearing against the bill (informal surveys at almost all programs showed that a majority of residents, regardless of specialty, felt that the proposed bill was too restricted and would actually compromise patient care). March fifteen came and went with the bill being tabled until July first. The Joint Committee on Health Care found the Coordination Committee report and recommendations too vague and requested more specific guidelines. By July first, however, the budget disaster was full blown and the bill was not acted upon. It has since been refiled but it is doubtful that any further action will be taken given the current legislative state of affairs.

This is both fortunate and unfortunate. The bill as it stands is unworkable for *any* program except, perhaps, pathology and radiation therapy. Substantial reform needs to be made with regards to resident working conditions and hours. More ancillary services need to be made available so that non-physician tasks are kept to a minimum. Every other night call as a standard is considered detrimental to residents health and well being, as well as unnecessary by most residents in all specialties. Attending physician supervision at some programs is inadequate.

Not only is number of hours worked per week an issue, what residents are doing in that time period must be considered vs. non-physician tasks, teaching/education vs. service. At this time, residents at Massachusetts General Hospital are mixing intravenous solutions after 9:00 p.m.! As recommended by the Coordination Committee report, It is best to give programs the chance to revamp on their own, but a specific time frame and deadline should be given. Voluntary reform from the inside is much preferred to legislative mandate from the outside. ■

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A Conversation with Richard Moore, President of the JUA

Editors Note: Richard Moore came to Springfield in April to introduce local agents who represent the JUA to a new computer system which he feels will greatly improve service to JUA customers. At that time, he met with the Hipprocrat and Dr. Lorne Smith, Chairman of the Committee on Insurance.

Q: How did the DPL system (Deferred Premium Liability) change things at the JUA?

A: The DPL system is a system I'm always called upon to *defend.* We didn't create it and administratively for the JUA, it's been a nightmare. There was a 400-500% increase in paper volume from the DPL.

The so-called Malpractice Reform legislation was passed in 1986. Then it became apparent what the outstanding bills for 1983-85 would be. The JUA would have collected the money by charging individual physicians the difference between what they paid and what the final rate was. The rates for 1986 were also delayed and an additional bill *was* sent. It's one thing to rebill for one year's worth of premium and another to rebill for three year's worth. Again, we could have rebilled you at 20% per year over five years.

The Medical Society lobbied successfully to have certain groups—retiring physicians, interns and residents— have their DPL obligation "forgiven". This resulted in a shifting of obligations between physician groups.

Then the Department of Insurance (DOI) refused to make the DPL a flat dollar amount. The DOI decided to make it a percentage of premium to allow a physician to change his specialty or reduce his coverage limits to reduce his DPL obligation. They thought they were doing physicians a favor. We felt the rationale was wrong because most physicians aren't willing to drop their limits in this climate. Sometimes we feel we are the organization that represents *all* the physicians. Doctors also don't understand that we are only one of the organizations involved in how these decisions are made.

Q: Has risk management shown itself to reduce litigation? Are there studies that show that risk management is cost effective?

A: What is true and it cannot be proved is that there is a "consciousness raising" element. Physicians participating in these programs have their consciousness raised about what they're doing in their practices. *Primum non nocere.* Physicians are violating that all the time. We're trying to discourage physicians from believing that they can do whatever they want because "they know the family".

Q: But don't you believe that physicians can be sued who have done nothing wrong? That's what we believe and fear.

A: At my level, I only see the claims where the payout is going to be more than $500 thousand and I don't see claims like that. I see the claims that the only capping effect on the award is the fact that the physician only has $1 million in coverage. We put it out to four experts and they're all negative on defending the claim.

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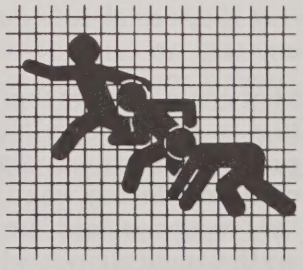

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A Conversation with Richard Moore, President of the JUA continued

Q: How are rates set for the various specialties? Are some groups subsidizing others?

A: The current situation is that all the lower level people are subsidizing the upper level people. Those with rates around the middle, like general surgeons, are paying their own way. Some of this exists because of DOI rules. When Harvard formed CRICO and left the JUA, your rates didn't go up because there are bad doctors at Harvard too. If all the obstetricians left the JUA, many people's rates would go down. The higher rated physicians are getting a Cadillac, but paying for a Chevrolet. We want to charge everyone as close to possible to what their costs are.

Q: When anesthesia received a discount what was that based on?

A: We don't like to give a group an upfront discount unless we're sure it's going to work. Dr. Ward from Seattle did a review of all anesthesia lawsuits in the US. In the study, all cases were reviewed to see if the presence of two pieces of equipment—the pulse oximeter and the end tidal CO2 recorder—would have prevented the loss. The conclusion was that with this equipment in place the loss wouldn't have happened. On that basis, we gave the discount to anesthesiologists who used the equipment. Anesthesiologists have only one type of most common expensive claim—anoxic brain injury—so in some respects they're a special case.

Q: Now the ER physicians just got a discount?

A: Hardly anyone will get this. The doctors involved have to record all their notes on a computer and these notes have to be sent for an audit every quarter. The audit is executed through a computer program that recognizes certain key words as high risk symptoms.

But we invite *any* specialty group to devise a plan that they can show reduces losses and we'll help in any way we can.

Q: What about charges that you are changing the practice in certain specialties—particularly ENT and general surgery—by the way you're devising risk categories for say, hand surgery or thyroid surgery?

A: "We've always held the position that what we see on the application is what the doctor is doing. We don't want to hire 20 people to go around to doctor's offices to check on what they're doing.

The problem we have with these issues, even with the big specialties, is the numbers. It's difficult enough in specialties where you know exactly what they're doing to come up with adequate statistics based on claims experience. If there are 50 doctors in the state doing, for example, occasional trauma cases, who are general surgeons, the physicians themselves have a lot better idea of what the risk is than the JUA. No matter how risky the activity, over some limited period of time, *no* claims will be filed.

Q: What about the $10 million DPL "bad debt"?

A: The calculation of the DPL planned on "bad debt". We knew there was going to be bad debt with people retiring *after* April 1, 1986 or leaving the state. Our terrible computer system made it difficult to collect the money.

We have a physician who owes us $130 thousand in "tail coverage" and DPL who we have cancelled. He's appealed this to the DOI *and* asked the Medical Society to *help* him make a deal with us. Meanwhile, I see on a recent case he's acting as a plaintiffs expert witness.

Q: What do you think of the proposed panel of physicians to review claims records and assign surcharges to "high risk" physicians?

A: Our people think that physicians are going to be very tough on their fellow physicians and we're going to have to hold them back. I'm an attorney and I think we're going to be sued on every case where we try to do anything of significance. We had to convince the DOI of the new system after the MMS convinced us. We had originally filed a bill to get rid of any sort of experience rating. Senator Melconian didn't endorse our idea and the review panel was the compromise.

Q: Now that you're sending out the newsletter we see that you win a lot of cases?

A: That's misleading. We try a ton of cases, but we settle the ones we have to settle and there's a lot of those. It galls us when we have a winner and we lose it for $3 million. That happens you know. We try to control our legal expenses, but there's always room for improvement there. We send back attorney's bills all the time. The defense attorney doesn't spend your money unless our claims people say it's O.K.

Brigid K. Glackin, M.D.

Managing Your Tax Liability Through Direct Investments

If you paid more in income taxes last year as a result of Tax Reform, you're not alone. With fewer deductions allowed and many shelters reduced or eliminated, more of the affluent investor's income is subject to taxation. The result: many affluent investors who paid more in income tax are paying a great deal of attention—all year round—to managing their tax liability.

THE CHANGING FACE OF TAX SHELTERS

Before Tax Reform, many affluent investors relied on investments known as tax shelters to help reduce their tax liability. Those tax shelters now commonly known as direct investments, have been greatly affected by Tax Reform. However, although many of the tax benefits associated with direct investments (or limited partnerships) have been reduced, these vehicles still carry some tax advantages. Many investors find the direct tax credits associated with investments in qualified housing attractive.

First, unlike corporations that are taxed an average of 52 percent of earnings, partnerships do not pay taxes on their earnings. This allows a partnership to pass a greater percentage of its earnings along to its partners.

Second, although Tax Reform has reduced, and will eventually eliminate in most cases, the amount of passive losses that may be applied to offset *regular* income, passive losses may still be applied against other *passive* income. The new law works like this: For 1989, only 20 percent of passive losses could be used to offset regular income. For 1990, the percentage is 10 percent. Passive losses incurred in 1991 and years following may *not* be applied against regular income. However, any passive losses not applied this year, (i.e. the remaining 90 percent of your loss) may be carried forward as "suspended losses" until an investor has passive income against which it may be applied.

Additionally, suspended losses may be applied against *regular* income if, and only if, the investment generating the losses is disposed of by the investor. In other words, if your loss generating activity is about to wind down or you are about to dispose of that investment, you may want to forgo taking the passive losses against your passive income in favor of carrying forward suspended losses which may later be applied against regular income.

However, losses from some direct investments can be applied against regular income while the loss generating activity is still in progress if the investor has an active or material involvement as a general partner.

Passive Income Generators

Many types of direct investments are *Passive Income Generators* that may offer tax advantages. When considering these investments, keep in mind that there are suitability standards that investors must meet in order to invest, particularly in the case of Private (Reg. D) Programs, where to be accredited you must have a net worth of at least $1 million, as well as an annual income of $200,000.00 or more for the prior two years and the current year.

Additionally, you should consider how you'll use the passive income, how long your investment range is, and how much risk you are willing to take. And of course, you'll need to examine each individual program on its own merits. A tax attorney or advisor can help you determine the appropriateness of a direct investment program as part of your overall investment portfolio.

Following is a brief description of various types of programs available and any additional tax advantage they may offer.

Oil and Gas Programs offer some significant tax advantages for individuals investing on a joint venture or general partnership basis: They may write off losses from public drilling funds as tax deductions against regular income. Income funds, which invest in producing oil and gas wells, provide partially sheltered cash flows.

Conventional real estate programs The range of investments runs from high-risk, fully leveraged real estate to low-risk, unleveraged, whether the property is traditional residential or commercial. Certain of these programs may be appropriate for retirement plans. Besides partially sheltered cash flows, appreciation potential from the eventual sale of the properties is an attractive benefit to these programs. Investors who "actively participate" in certain rental real estate activities may, depending upon their adjusted gross income, be able to apply up to $25,000 of their losses against their regular income.

Qualified housing programs raise funds to support government subsidized housing. Under section 42 of the new tax code, taxpayers who invest in qualified housing programs are entitled to utilize tax credits equal to the tax on $25,000 of income. Someone in the 28 percent tax bracket may use up to $7,000 in credits, while someone in the 33 percent tax bracket can use up to $8,250 in credits per year. Like traditional real estate programs, these programs also have the added benefit of potential capital appreciation.

Research and development partnerships present investors with the opportunity to participate in the development of new products. If a product is successful investors may receive cash distributions—which can be partially sheltered—from the partnership.

Equipment leasing programs and *film and cable TV partnerships* also generate passive income which may be applied against passive losses. ■

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Pathways:
A Cancer Resource Directory

By now many patients and physicians in Western Massachusetts and Northwestern Connecticut have received copies of ***Pathways: A Cancer Resource Directory.*** This publication was funded by the Baystate Medical Center Auxiliary and is an extremely useful manual for cancer patients. There are lucid explanations of what constitutes cancer treatment and which specialties have major involvement in treatment and diagnosis. There are helpful tips in finding one's way around the "system." The side effects of cancer and its' treatment are addressed in general terms, emphasizing what a patient has a right to expect from the health care professional.

Although much of the above is covered in other "generic" publication, ***Pathways*** is unique in that it contains a thoroughly researched section of phone numbers and addresses for agencies and other sources of help in the region. Cancer information sources, Home health care agencies, Hospice organizations, sources of legal services, support groups, cancer screening programs, transportation resources and so on are all listed.

This is an excellent manual for a physician to present to the patient when he or she has to "break the bad news." It is a concrete sign of his or her concern, and begins the process of "empowering" the patient to take charge of the situation insofar as possible.

Pathways was developed by a consortium of cancer professionals. Copies can be obtained from:

Sandra Turner, B.S.N., M.Ed.
Oncology Program Manager
Wright II
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199 ■

IN MEMORIAM

AARON H. BURKIN, M.D., was born in Boston, graduated from Brandeis University, and received his medical degree from Boston University. He leaves his wife, the former Sandra Grocer; a son, John, and a daughter, Brenda. Memorial contributions may be made to the Jewish Nursing Home of Western Massachusetts.

FREDERICK POST, M.D., was born in Westfield, graduated from Dartmouth College, and obtained his medical degree from Yale University. He leaves his two daughters, Lee and Faith; and four grandchildren. Memorial contributions may be made to the Clarke School for the Deaf, Northampton.

H. BERNARD TILLMAN, M.D., was born in Springfield, graduated from Brown University, and obtained his medical degree from Cornell University. He founded, and was chairman of, the allergy service at Baystate Medical Center. He leaves his wife, the former Beverly Fine, and his children Arnold, Stephen, and Cynthia; and four grandchildren. Contributions may be made to the Max and Ida Millman Scholarship Fund, care of the Hampden District Medical Society or Kodimoh Synagogue.

J. FLETCHER WONSON, M.D., was born in Gloucester, graduated from Bowdoin College, and obtained his medical degree from Tufts University. He leaves his wife, the former Edna Petersen, two daughters, Pamela and Candace, and six grandchildren. Memorial contributions may be made to Noble Hospital. ■

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H.D.M.S. Transactions

The Annual Meeting was held April 24, 1990 at the Old Storrowton Tavern in West Springfield. The new officers of the Society (listed on the masthead) were nominated and elected. Drs. John Tate and Paul Moore were honored for 50 years of service to medicine.

The Public Health Committee heard Mrs. Canning, the Director of Nursing for the Springfield Health Department, describe the current problems resulting from understaffing the Public Health Nursing positions. These nurses spend 85% of their time dealing with school age children, holding immunization clinics, doing maternal and child home visits, reporting communicable disease, and administering various medications including psychotropics and antitubuculars. It is nationally recommended that there be one nurse per every 750 students; in Springfield the ratio is on nurse per 1600 to 2000 students. Further cutbacks are likely unless the mayor is persuaded to classify Public Health Nursing under "Essential Services". Mrs. Canning's request for support for this reclassification was forwarded to the Executive Committee.

The Medico-Religious committee met on May 3. The Sixth Annual Medical Ethics Forum will be held October 24th. Reverend Stanley S. Harakas will present and discuss a case study. Afterwards, a panel made up of various professionals will comment on the issue. The tentative title will be "When is Enough Enough?".■

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Weld Outlines Health-Care Reforms

Speaking to the Massachusetts Medical Society in Springfield, the former U.S. Attorney proposed measures encouraging doctors to stay in Massachusetts, making health insurance more accessible to small businesses, and reducing the amount of "green tape" involved in hospital financing.

"Today, we have the most expensive health care system in the world in Massachusetts, yet many people working in it feel abused and mistreated by it, and others feel left out" Weld said.

Weld said that as governor, he would take steps to improve the relationship among state government, the medical profession and the health care community.

"The state has issued a lot of orders and regulations, but I don't believe there's been much of an attempt to establish a real two-way relationship," he said. "That's bad for providers, bad for medicine, and, ultimately, bad for the people who depend on the health care system."

Specifically, Weld proposed:

- A compact between the physician community and state government that would design a no-fault medical malpractice insurance system. In return for no-fault insurance, doctors would help devise practice standards that "can help us separate negligent medical care from non-negligent care," Weld said.
- Modification of the ban on balanced billing for wealthier patients.
- Loan forgiveness and scholarship programs for physicians willing to practice in under-served areas in the state such as Cape Cod, western Massachusetts and the Roxbury section of Boston.

"How can we say we're promoting affordable health care when the folks with the keys to the palace—the physician community—say Massachusetts is a lousy place to practice medicine?" Weld asked.

Weld also proposed reforming the small business health insurance system by allowing small companies and self-employed individuals to purchase catastrophic coverage.

He said Massachusetts should follow the lead of Connecticut in passing reforms that encourage the insurance industry to manage rather than avoid the risk when dealing with small companies.

Such reforms would lead to insuring 65 percent of the Massachusetts population that currently is not insured, and are preferable to the universal health care law, which will force small companies to insure their employees or pay a $1,680 per-employee fee to the state, Weld said.

"This kind of reform—which is designed to make health insurance more accessible to small businesses instead of simply hitting them over the head with a mandate—is the kind of reform we needed in Massachusetts in 1988, and didn't get," Weld said.

Weld also proposed simplifying the hospital financing system, including the rate-setting and Medicaid payment processes, by eliminating what Boston University Professor Alan Sager calls "green tape."

Noting that the same physician bills to Medicaid can be returned repeatedly because of clerical and technical errors, Weld said: "All technical errors should be noted and adjusted the first time Medicaid reviews the bill. After that, it's the state's fault, and the bill should be paid."

Weld said he would also push the hospital financing system toward prospective, rather than retroactive, rate setting.

"Hospitals ought to be spending their time worrying about delivering care, and not about retroactive reimbursement issues," he said.

In an effort to help control Medicaid costs, Weld proposed offering tax incentives to people who care for their parents or relatives, rather than institutionalizing them. ■

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Welcome New Members

Robert S. Howe, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN	May 19, 1956
PREMED:	Case Western Reserve University, Ohio 1974-1978
MEDICAL:	University of Connecticut 1978-1982
INTERNSHIP:	Wilmington Medical Center, Delaware 1982-1983
RESIDENCY:	Medical Center of Delaware 1983-1986
FELLOWSHIP:	Thomas Jefferson University 7/86-9/86 University of Pennsylvania 10/86-1989
SPECIALTY:	Obstetrics/Gynecology/Reproductive Endocrinology

Alfred L. McKee, Jr., M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	December 18, 1956
PREMED:	Allegheny College, Pennsylvania 1975-1978
MEDICAL:	New York Medical College, New York 1978-1982
INTERNSHIP:	Univ. of Health Center Hospital of Pittsburgh 1982-1985
RESIDENCY:	Univ. of Health Center Hospital of Pittsburgh 1982-1985
FELLOWSHIP:	Dartmouth Medical School 1985-1989 (June)
SPECIALTY:	Internal Medicine/Hematology/Oncology

John P. Bigos, M.D.
Baystate Medical Hospital
759 Chestnut Street
Springfield, MA 01199

BORN:	November 20, 1955
PREMED:	Boston College and Bowdoin College 1973-1977
MEDICAL:	University of Connecticut 1977-1982
INTERNSHIP:	Hartford Hospital 1982-1983
RESIDENCY:	Danbury Hospital and Yale University School of Medicine 1983-1985
FELLOWSHIP:	Norwalk Hospital and Yale University School of Medicine 1987-1989
SPECIALTY:	Internal Medicine/Pulmonary

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continued from previous page

Viriato M. Fiallo, M.D.
780 Chestnut Street
Springfield, MA 01107

BORN:	December 11, 1956
PREMED:	Universidad Nacional Pedro Henriquez Urena Santo Domingo, Dominican Republic 1972-1975
MEDICAL:	Universidad Nacional Pedro Henriquez Urena 1975-1980
INTERNSHIP:	Baystate Medical Center 1982-1983
RESIDENCY:	Baystate Medical Center 1983-1985 and 1986-1989
FELLOWSHIP:	Baystate Medical Center July 1989-December 1989 Surgical Research July 1985-June 1986
SPECIALTY:	General Surgery

Robert D. Ficalora, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	July 8, 1956
PREMED:	Fairfield University, Connecticut 1974-1978
MEDICAL:	State University of New York, Stonybrook 1978-1982
INTERNSHIP:	Baystate Medical Center 1982-1983
RESIDENCY:	Baystate Medical Center 1983-1985
SPECIALTY:	Internal Medicine/Administrative Medicine

William B. Freedberg, M.D.
Medical West
230 Main Street
Agawam, MA 01001

BORN:	November 11, 1942
PREMED:	Harvard College 1960-1964
MEDICAL:	Harvard-MIT Health Sciences, Boston, Mass. 1973-1974 University of Cincinnati College of Medicine 1974-1977
INTERNSHIP:	Jewish Hospital of Cincinnati 1977-1978
RESIDENCY:	Jewish Hospital of Cincinnati 1978-1980
FELLOWSHIP:	Harvard Medical School 1970-1974
SPECIALTY:	Internal Medicine

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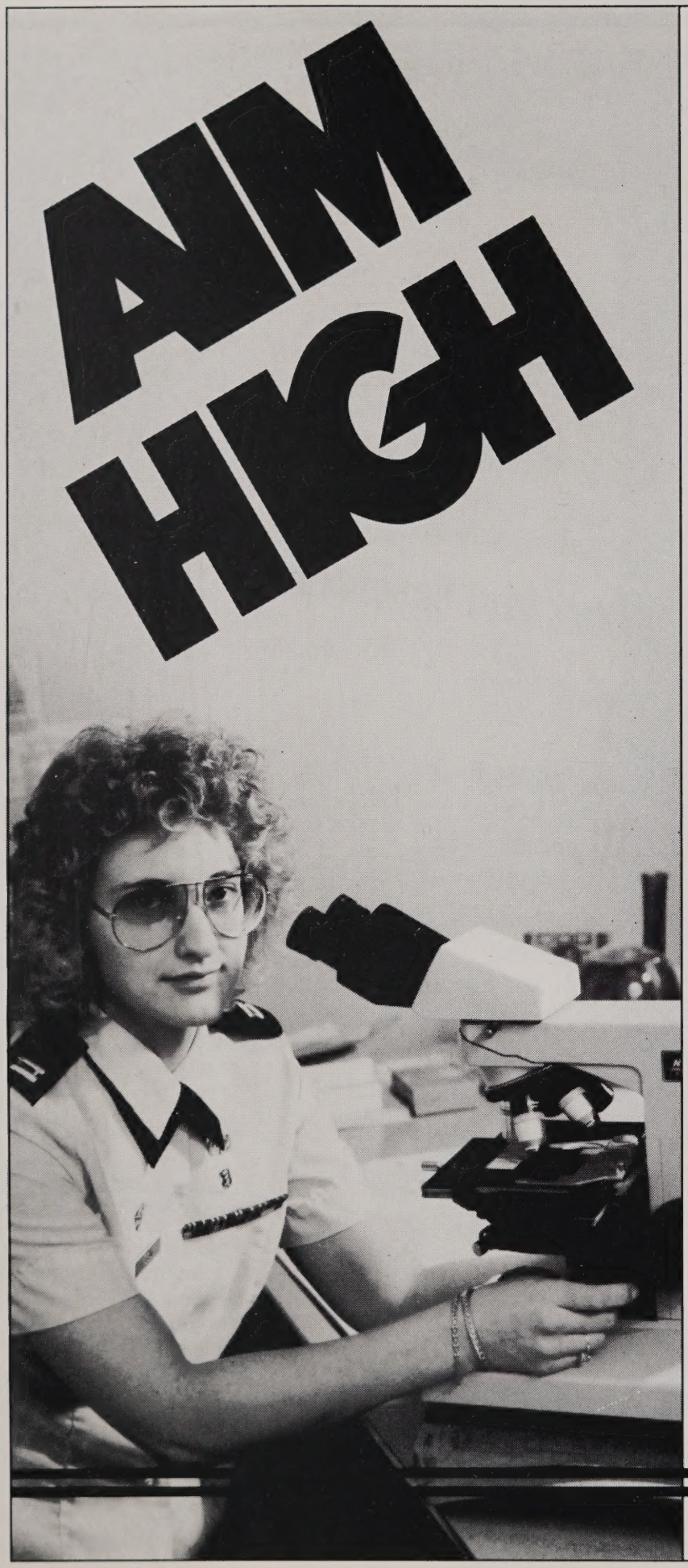

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